COMMON PROBLEMS FOUND DURING LIFE AND HEALTH MARKET CONDUCT EXAMINATIONS

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

REVISED 2005

The State Corporation Commission's Bureau of Insurance has accumulated the following information to inform insurers of the compliance problems frequently found during Life and Health Market Conduct Examinations. Its purpose is not to provide specific guidance on how a company should conduct business in Virginia, but to point out the areas in which the Life and Health Market Conduct Section has found problems in the past. It should be noted that references within this document to Companies' failures to comply with certain statutes or rules refer to non-compliance with all or part of such statutes or rules.

This list should not be considered all-inclusive, and the company should continue to review Title 38.2 of the Code of Virginia (the Code), appropriate chapters of the Virginia Administrative Code (VAC) and the Bureau's administrative letters to assure compliance.

The common problems identified in this document are a result of examinations conducted during the last 5 years. As a result of these Market Conduct Examinations, insurers have had to remit to the Treasurer of Virginia monetary settlements ranging from $0 to over $180,000. Some insurers also had to refund or properly process claims resulting in hundreds of thousands of dollars being refunded or paid to insureds or providers.

Any questions regarding the contents should be communicated to:

COMMONWEALTH OF VIRGINIA
State Corporation Commission
Bureau of Insurance
Market Conduct Section (Life and Health)
P. O. Box 1157
Richmond, Virginia 23218
(804) 371-9532
Fax (804) 371-9821
bureauofinsurance@scc.virginia.gov

MANAGED CARE HEALTH INSURANCE PLANS (MCHIP)

Failure to make required disclosures and representations to enrollees. Section 38.2-5803 of the Code requires the carrier to provide to MCHIP-covered persons a list of names and locations of affiliated providers, a description of the service area, a description of the method of resolving complaints, and a notice that MCHIPs are subject to regulation by both the State Corporation Commission's Bureau of Insurance and the Virginia Department of Health. This Section also requires that a prominent notice be included in the Evidence of Coverage referencing how the insured may contact the office of the Managed Care Ombudsman for assistance. The examinations revealed that approximately 28% of the insurers failed to comply with the above Section.

Failure to establish and maintain a complaint system for each MCHIP. Section 38.2-5804 of the Code requires a health carrier to establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints. The examinations revealed that approximately 18% of the insurers failed to comply with the above Section. 14 VAC 5-210-70 H 1 states that health maintenance organizations shall establish and maintain a grievance or complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints. Of the HMOs examined, approximately 31% failed to comply with the above regulation.

ETHICS AND FAIRNESS

Failure of provider contracts to contain specific provisions. Section 38.2-3407.15 B of the Code requires that every provider contract entered into, amended, extended or renewed on or after July 1, 1999, shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services.

Section 38.2-3407.15 of the Code was effective July 1, 1999. The Bureau of Insurance conducted Target Market Conduct Exams of provider contracts entered into, amended, extended or renewed on or after that date. The findings revealed that of the 98 insurers examined, 72% failed to comply with this Section.

ADVERTISING/MARKETING COMMUNICATIONS

Failing to maintain an advertising file and failure to comply with specific requirements. 14 VAC 5-40-60 B and 14 VAC 5-90-170 A require each insurer to maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement with a notation attached indicating the manner and extent of distribution and the form number of any policy advertised. It is the opinion of the Examiners that the "manner and extent of distribution" should include an indication of when the use of the advertisement began, the

method of distribution, when it was discontinued, the number of advertisements used, and the intended audience. The examinations revealed that approximately 42% of the insurers failed to comply with the above regulations.

When violations of these regulations are cited, it does not necessarily mean that the advertisement/marketing communication has actually misled or deceived any individual to whom the advertisement/marketing communication was presented. An advertisement/marketing communication may be cited for violations of certain sections of the regulations if it is determined by the Bureau of Insurance that an advertisement/marketing communication has the tendency or capacity to mislead from the overall impression that the advertisement/marketing communication may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

Every carrier shall maintain control over the method of dissemination, content, and form of all advertisements/marketing communications regardless of by whom written, created, designed, or presented.

(Accident and Sickness)

14 VAC 5-90-50 A requires that the format and content of an advertisement be sufficiently complete and clear to avoid the capacity or tendency to mislead or deceive. The examinations revealed that approximately 26% of the insurers marketing accident and sickness products in Virginia failed to comply with this requirement.

14 VAC 5-90-60 A 1 prohibits the omission of or use of information, words, or phrases, if such omission or use would have the capacity or tendency to mislead as to the nature or extent of any policy benefit payable, loss covered, or premium payable. The examinations revealed that over 29% of the insurers marketing accident and sickness products in Virginia failed to comply with this requirement.

14 VAC 5-90-60 A 2 requires that no advertisement contain or use words or phrases in a manner which tends to exaggerate any benefits beyond the terms of the policy. The examinations revealed that approximately 21% of the insurers marketing accident and sickness products in Virginia used such words or phrases.

14 VAC 5-90-90 A requires that any statistical information relating to an insurer or policy be relevant, and prohibits its use unless the statistics reflect all of the relevant facts. Also, 14 VAC 5-90-90 C requires the source of any statistic used in an advertisement to be identified in such advertisement. The examinations revealed that approximately 27% of the insurers marketing accident and sickness products in Virginia failed to comply with the above requirements.

14 VAC 5-90-130 A requires that the actual name of the insurer and the form number or numbers of the policy being advertised be included in the advertisement and made clear. The examinations revealed that over 32% of the insurers marketing accident and sickness products in Virginia failed to include the form number of the policy advertised or the actual name of the insurer in its advertisements.

14 VAC 5-90-160 states that an advertisement shall not contain statements, which are untrue in fact or by implication misleading, with respect to assets, corporate structure financial standing,

age, or relative position of the insurer in the insurance business, and prohibits the use of a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation. The examinations revealed that over 21% of the insurers marketing accident and sickness products in Virginia failed to contain the scope and extent of the recommendation made by a commercial rating system in its advertisements.

Violations of the regulations above also place insurers in violation of §§ 38.2-502, 38.2-503, and 38.2-4312 A of the Code, which prohibit a company from placing before the public a representation relating to policy benefits or the business of insurance that is deemed to be untrue, deceptive, or misleading. (Effective August 4, 2004, 14 VAC 5-90-10 et seq. was amended.)

POLICY AND OTHER FORMS

Use of policy forms prior to filing and receiving approval. Sections 38.2-316 and 38.2-4306 A 2 of the Code and 14 VAC 5-210-110 A set forth the filing and approval requirements for policy/contract forms, applications, evidences of coverage, riders, amendments, and endorsements that are to be delivered or issued for delivery within this Commonwealth. The examinations revealed that approximately 75% of the insurers failed to file one or more forms for approval before use.

Failure to file Explanation of Benefit (EOB) forms. Section 38.2-3407.4 A of the Code requires each company issuing accident and sickness coverage to file its EOBs with the Commission for approval. These forms are subject to the requirements of § 38.2-316 or § 38.2-4306 of the Code, as applicable. The examinations revealed that 45% of the insurers failed to file for approval one or more EOBs.

Failure to file schedule of charges (HMO only). Section 38.2-4306 B 1 of the Code and 14 VAC 5-210-110 B prohibit the use of schedules of charges or amendments to the schedules of charges for enrollee coverage for health services until a copy of the schedule or amendment has been filed with the Commission. Of the HMOs that were examined, approximately 23% failed to file a complete schedule of charges to include all factors used in the calculation of such charges.

AGENTS

Failing to license and appoint agents as required. Sections 38.2-1822 A and 38.2-4313 of the Code require that a person be licensed prior to soliciting contracts. Section 38.2-1833 A 1 requires a company to, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent. Of the insurers that were examined, approximately 42% failed to comply with § 38.2-1822 A, approximately 58% failed to comply with § 38.2-1833 A 1 and 19% of the HMOs failed to comply with § 38.2-4313 of the Code by failing to license and/or appoint agents as required.

Payment of commissions to agents who are not licensed or appointed. Section 38.2-1812 A of the Code prohibits the payment of commissions or other valuable considerations to an agent or agency that is not appointed and that was not licensed at the time of the transaction. Of the insurers reviewed, approximately 47% paid commissions to unlicensed/unappointed agents.

Failure to notify agent/Commission of appointment termination. Section 38.2-1834 C of the Code requires that an agent be notified within 5 days and the Commission within 30 days upon termination of an appointment. Of the insurers reviewed, over 45% failed to notify the agent or Commission of appointment terminations as required.

UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT/INSURANCE REPLACEMENT

Failure to provide required Adverse Underwriting Decision (AUD) Notice. Section 38.2-610 of the Code requires that, in the event of an adverse underwriting decision on an applicant that is individually underwritten, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission. Of the insurers reviewed, the majority did not individually underwrite so this Section was not applicable. Approximately 23% failed to comply with the above Section.

COMPLAINTS

Failure to maintain a complete record of complaints. Section 38.2-511 of the Code requires that a complete record of complaints be maintained for all complaints that the carrier has received since the date of the carrier's last examination, provided that the record of complaints of a health carrier subject to Chapter 58 of this title is retained for no less than 5 years. Insurers not subject to Chapter 58 must maintain a record of all written complaints for 3 years. The record shall indicate the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. Of the insurers that were examined, over 35% failed to maintain a record of complaints as required.

CLAIMS

Failure to affirm or deny a claim within a reasonable period of time. Section 38.2-510 A 5 of the Code prohibits, as a general business practice, the failure to affirm or deny claims within a reasonable time after proof of loss statements have been completed. 14 VAC 5-400-60 A (if applicable) requires that unless otherwise stated in the policy, within 15 working days after receipt by the company of properly executed proofs of loss, a first party claimant shall be advised of the acceptance or denial of the claim by the company. Over 45% of the companies examined failed to affirm or deny a claim within a reasonable time period.

Failure to pay interest on claim proceeds as required. Section 38.2-3115 B (life only) of the Code states that interest upon the principal sum shall be paid at an annual rate of 2-1/2 percent or the annual rate currently paid by the insurer on proceeds left under the interest settlement option, whichever is greater. Section 38.2-3407.1 (accident and sickness insurance only) of the Code requires that interest be paid on claims from the 15th work day after the receipt of proof of loss. Section 38.2-4306.1 (HMO only) of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment. Of the insurers examined, over 60% failed to pay interest as required.

EXAMINATIONS

Examinations; how conducted. Section 38.2-1318 C of the Code requires that every company or person from whom information is sought, its officers, directors, and agents shall provide the examiners convenient access at all reasonable hours to its books, records, files, securities, accounts, papers, property, assets, business and affairs of the company being examined or those of any person, including any affiliates or subsidiaries of the person examined, that are relevant to the examination. The examinations revealed that 27% of the insurers examined failed to comply with the requirements of this Section.